

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County <u>Johnson</u>	Township <u>Holden</u>	Registration District No. <u>427</u>	File No. <u>25405</u>	23505	
or	Village <u>Holden</u>	Primary Registration District No. <u>4253</u>	Registered No. <u>26</u>		
or	City <u>Holden</u>	St. <u>      </u>	Ward <u>      </u>	[If death occurred in a hospital or institution, give its NAME, instead of street and number]	
FULL NAME <u>Bearf Jayme Wood</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OR DIVORCED <input type="checkbox"/> (Write the word)	DATE OF DEATH <u>July 21</u> 191 <u>2</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>June 15</u> 191 <u>2</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>June 18</u> , 191 <u>2</u> to <u>July 20</u> , 191 <u>2</u> , that I last saw her alive on <u>July 1st</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>6 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Acute Indigestion</u> <u>1180</u> <u>16113</u> (Duration) yrs. <u>1</u> mos. <u>2</u> ds.		
AGE <u>1</u> month, yrs. <u>1</u> mos. <u>2</u> ds. or LESS than 1 day, yrs. or min.?					
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>0</u>					
BIRTHPLACE (City or town, State or foreign country) <u>Holden Mo.</u>			Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.		
PARENTS	NAME OF FATHER <u>Unknown</u>		(Signed) <u>Emory Thompson</u> M. D. <u>July 22</u> 191 <u>2</u> (Address) <u>Holden, MO</u>		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.		
	MAIDEN NAME OF MOTHER <u>Pattie Wood</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Clinton, Ia.</u>		Where was disease contracted if not at place of death? Former or usual residence _____		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. H. Rawson</u> (ADDRESS) <u>Holden Mo.</u>			PLACE OF BURIAL OR REMOVAL <u>Rawson</u> UNDERTAKER <u>None</u>		
JUL 22 1912 <u>Edw. C. Anderson</u> REGISTRAR			DATE OF BURIAL <u>July 20</u> 191 <u>2</u> ADDRESS _____		

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first; the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

*coma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



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MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT BUREAU OF VITAL STATISTICS  
CEIVE A FEE FOR CERTIFICATES  
UNTIL THEY ARE COMPLETED AS  
PRESCRIBED BY LAW. CERTIFICATE OF DEATH

PLACE OF DEATH  
County Johnson  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Holden (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 427 File No. 23405  
Primary Registration District No. 4253 Registered No. 36

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

Pearl Lagrene Wood

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>June 18</u> , 19 <u>12</u> (Month) (Day) (Year)		
AGE <u>1</u> yrs. <u>2</u> mos. <u>2</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Holden Mo.</u>		
PARENTS	NAME OF FATHER <u>Unknown</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____	
	MAIDEN NAME OF MOTHER <u>Lottie Wood</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Coin La.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
July 20, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 28, 1912, to July 20, 1912, that I last saw her alive on July 20, 1912, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH\* was as follows:  
Septicemia and Acute Indigestion

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Emory Thompson M. D.  
July 22, 1912 (Address) Holden, Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Branson  
(ADDRESS) Holden Mo.

Filed \_\_\_\_\_ 1912

REGISTRAR

PLACE OF BURIAL OR REMOVAL

Fairview

UNDERTAKER

none

DATE OF BURIAL

July 26, 1912

ADDRESS

Original file, date JUL, 1912

All information called for must be written on this Supplementary Certificate

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[Approved by U. S. Census and American Public Health Association]

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